Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: Previous MFDR #s	M4-09-A527-01 M4-09-3661-01 & M4-09-5521-01
CANTON HEALTHCARE SYSTEMS 300 S. MAIN CANTON, TX 75103		
Respondent Name and Box #:		
DEEP EAST TEXAS SELF INS BOX # 01		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: No position summary was submitted; however, the Requestor's rationale from the Table of Disputed Services states, "Pre-authorized Services".

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $20,000.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…It is the carrier's position that the documentation provided by Canton Healthcare does not support that an 8 hour per day Chronic Pain Management Program (CPM) was provided on the 24 dates for which the provider is requesting payment. The documentation does not support that CPM services were provided for 8 hours each day and the provider has not documented a positive outcome of the CPM program which would be expected had the program services been delivered as alleged by Canton Healthcare. Further more, the requestor has not provided an explanation as to how the information and documentation they submitted supports that they performed eight hours of services per day which met the requirements for a Chronic Pain Program…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
11/26/2007 thru 02/06/2008	97799-CP*	1 - 12	$18,925.00
Total:			$18,925.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code (TLC) §413.011(a-d) titled *Reimbursement Policies and Guidelines* and 28 Texas Administrative Code (TAC) §134.202 titled *Medical Fee Guideline for Professional Services* effective for professional medical services provided on or after August 1, 2003 set out the reimbursement guidelines.

*Note: The Requestor billed CPT code 97799-CP-AQ on the CMS-1500; however, on the DWC-60 Table, the Requestor listed 97799-CP.

1. This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under §133.305 (a) (1) (A).

2. TLC §413.031(c) states, "In resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules…"

3. Review of the CMS-1500s submitted by the Requestor to the Division indicates that a Chronic Pain Management (CPM) program was billed with CPT code 97799-CP-AQ, 8 hrs/day on the 24 dates of service in dispute.

4. The services listed above were denied by the Respondent with the following denial reason codes:
   - 150 - payment adjusted because the payer deems the information submitted does not support this level of service;
   - 151 - payment adjusted because the payer deems the information submitted does not support this many services; and
   - 152 - payment adjusted because the payer deems the information submitted does not support this length of service
   - W4 – no additional reimbursement allowed after review of appeal/reconsideration; and
   - W9 – unnecessary medical treatment based on peer review.

5. Review of the preauthorization letters from Review Med dated 11/12/2007, 11/30/2007; and 1/17/2008 indicates the following:
   - Preauthorization letter dated 11/12/2007 indicates approval for initial 10 sessions of chronic behavioral pain management (CPM), 8 hours/day, 5 days/week x 10 days with a start date of 11/8/2007 and end date of 11/28/2007.
   - Review of the Requestor's submitted documentation reveals the CPM program began on 11/13/2007 and the last day of the first 10-day preauthorized session was completed on 11/30/2007. (10 sessions = 11/13/2007; 11/14/2007; 11/15/2007; 11/16/2007, 11/19/2007; 11/20/2007; 11/26/2007; 11/28/2007; 11/29/2007 and 11/30/2007).
   - Preauthorization letter dated 11/30/2007 indicates approval for an additional 10 sessions of CPM, 8 hours/day, 5 days/week x 2 weeks with a start date of 12/5/2007and end date of 12/21/2007.
   - Review of the Requestor's submitted documentation reveals the additional sessions of CPM were conducted on 12/10/07; 12/11/2007; 12/12/2007;12/13/2007; 12/14/2007; 12/17/2007; 12/20/2007 and 12/21/2007 (8 sessions).
   - Preauthorization letter dated 1/17/2008 indicates approval for another 10 additional sessions of CPM with a start date of 1/14/2008 and end date of 2/28/2008.
   - Review of the Requestor's submitted documentation reveals the additional sessions of CPM were conducted on 1/22/08; 1/23/08; 1/24/08; 1/25/08; 1/28/08; 1/29/08; 1/31/08; 2/4/08; 2/5/08; and 2/6/08 (10 sessions).
   - Review of the Preauthorization letters indicates "program approved per ODG guidelines"; however, per 28 TAC §137.10 *Return to Work Guidelines*, insurance carriers and health care providers shall use *The Medical Disability Advisor, Workplace Guidelines for Disability Duration (MDA),* as the Division's return-to-work guidelines.

6. Review of the EOB dated 2-8-08 and Reconsideration EOB dated 2/21/2008 reveals that the Respondent denied disputed DOS 11/26/2007; 11/28/2007; 11/29/2007; 11/30/2007; 12/10/07; 12/11/2007; 12/12/2007; 12/13/2007; 12/14/2007; 12/17/2007; 12/20/2007; and 12/21/2007 with denial reason "W9 - unnecessary medical based on peer review."

7. 28 TAC §134.600(c)(1)(B) states that the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p)(10) of this section when preauthorization was approved prior to providing the health care; therefore, the "W9" denial reason is not supported.

Reimbursement

8. 28 TAC §134.202 (e) states that payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows:…(5) (A)(ii) If the program is not CARF-accredited…the hourly reimbursement shall be 80% of the MAR. 28 TAC §134.202 (e) (5) (E) Chronic Pain Management states in part, (ii) Reimbursement shall be $125.00 per hour. Units of less than 1 hour shall be prorated in 15-minute increments. A single increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

9. The Requestor seeks reimbursement for 8 hours per session for 24 sessions at the non-CARF rate of $100.00/hour. Review of the Requestor's submitted documentation supports the number of hours billed except as noted.

10. The Requestor submitted two pieces of evidence to support the injured employee's time spent in the CPM program. One piece of evidence was a "time in/time out" daily time sheet and the other piece of evidence was the daily activity log sheet. The Division thoroughly reviewed both pieces of documentation and chose to use the daily activity log sheet to determine the hours spent in the CPM program, as the daily activity log sheet was more specific.

11. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the Requestor and Respondent during dispute resolution and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does support that reimbursement is due to the Requestor.

12. The Division concludes that the Requestor met its burden of proof to support its position that reimbursement is due as follows:

Dos 11/26/07: billed 8 hrs; 7 hr 21 min documented = 7 hrs 15 min reimbursement due per paragraph #8 above
Dos 11/28/07 thru 11/30/07: billed 8 hrs/day x 3 days; 8 hrs/day documented
Dos 12/10/07 and 12/11/07: billed 8 hrs/day x 2 days; 8 hrs/day documented
Dos 12/12/07: billed 8 hrs; 7 hr 52 min documented = 7 hr 45 min reimbursement due per paragraph # 8 above.
Dos 12/13/07 and 12/14/07: billed 8 hrs/day x 2 days; 8 hrs/day documented
Dos 12/17/07 thru 12/21/07: billed 8 hrs/day x 5 days; 8 hrs/day documented
Dos 1/22/08: billed 8 hrs; 7 hrs 48 min documented = 7 hrs 45 min reimbursement due per paragraph #8 above
Dos 1/23/08: billed 8 hrs; 7 hrs 45 min documented
Dos 1/24/08: billed 8 hrs; 7 hrs 50 min documented = 7 hrs 45 reimbursement due per paragraph #8 above
Dos 1/25/08: billed 8 hrs; 7 hrs 45 min documented = 7 hrs 45 min reimbursement due per paragraph #8 above
Dos 1/28/08: billed 8 hrs; 7 hrs 54 min documented = 8 hrs reimbursement due per paragraph #8 above
Dos 1/29/08: billed 8 hrs; 7 hrs 49 min documented = 7 hrs 45 min reimbursement due per paragraph #8 above
Dos 1/31/08: billed 8 hrs; 7 hrs 48 min documented = 7 hrs 45 min reimbursement due per paragraph #8 above
Dos 2/4/08: billed 8 hrs/day; 7 hrs 55 min documented = 8 hrs reimbursement due per paragraph #8 above
Dos 2/5/08: billed 8 hrs; 7 hrs 43 min documented = 7 hrs 45 min reimbursement due per paragraph #8 above
Dos 2/6/08: billed 8 hrs/day; 7 hrs 55 min documented = 8 hrs reimbursement due per paragraph #8 above

Note: Per telephone conversation with Requestor's representative, Cathy Zacharias, the injured employee took a 10 or 15 minute lunch break on most days.

As a result, the amount ordered is:

7 hrs 15 min x $100.00/hr = $725.00 x	1 day	= $ 725.00
7 hrs 45 min x $100.00/hr = $775.00 x	8 days	= $ 6,200.00
8 hrs x $100.00/hr = $800.00 x	15 days	= $12,000.00
	24 days	$13,525.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, 133.305, 133.307, 137.10, 134.600, 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $13,525.00 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Manager, Medical Fee Dispute Resolution	Date

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.